Recover Health Contracted Worker Attestation

Contractor Name: Recover Care___________ **Recover Heath Office Location:**________________**Date:** ___________
Worker Name: ____________________________**Discipline**________ **Clinician's License Number**________________

COMPLETED BY CONTRACTOR: Contractor has a contractual agreement to provide the following requirements and is responsible for retaining evidence of completion in the employee file.

- State background check (BID/DHS)
- OIG / SAM Exclusion Clearance
- HIPAA Privacy Notice
- Recover Health Job Description (HHA / RN)
- TB Screening & Communicable Disease Health Screening Form
- Tuberculosis Testing Results per Recover Health Policy
- Relias Transcript including completion of the following courses:
  - Recover Health Mission Statement
  - Home Care Bill of Rights
  - Emergency Preparedness
  - Infection Control/Blood Borne Pathogens
  - Vulnerable Adult and Child per State Regulation
  - Handling Client Complaints and reporting complaints to Ombudsman
  - Fraud & Abuse Compliance Training
  - Alzheimer’s Disease Training (MN only)
- Copy of Active RN License, if applicable
- Copy of Active CNA License (WI Only)
- Copy of Active CNA License
  - MVR Check through Verified Credentials
  - A Copy of Employee’s Recover Care Completed Orientation Packet

ANNUAL EDUCATION: The Contractor has a contractual agreement to provide the following annual requirements and is responsible for retaining evidence of completion in the employee file.

- 12 Hours of Training, including:
  - Emergency Preparedness
  - Infection Control/Blood Borne Pathogens
  - Vulnerable Adult and Child per State Regulation
  - Fraud & Abuse Compliance Training
  - Home Care Bill of Rights (MN Only)
  - Alzheimer’s Disease Training (MN Only)
  - Annual Performance Review

Acknowledgment: Contractor Representative attests compliance of all requirements outlined above.

COMPLETED BY RECOVER HEALTH:

☐ Clinician license online verification: verification: Restriction□No □Yes
☐ RN Skill Competency Evaluation

Acknowledgment: Administrator agrees all training was completed and approves contracted staff to be scheduled.

Administrator Name:____

Signature:____Date:________________